REDACTED

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SURESH GANDOTRA, M.D. Certificate No. A-29677 Respondent.	No. 06-90-1180

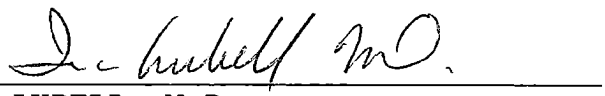
DECISION

The attached Stipulated Decision in case number 06-90-1180 is hereby adopted by the Division of Medical Quality of the Medical Board of California as its decision in the above entitled matter.

This Decision shall become effective on January 20, 1995.

IT IS SO ORDERED January 20, 1995.

DIVISION OF MEDICAL QUALTY
MEDICAL BOARD OF CALIFORNIA

By 
IRA LUBELL, M.D.
Chairperson

January 20, 1995

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

In the Matter of the Accusation and Surrender of Licensure of: SURESH GANDOTRA, M.D. DOB: [redacted] 215 S. Owens Drive Anaheim, CA 92807 Physician's and Surgeon's Certificate No. A29677 Fictitious Name Permit El Norte Clinica Medica 342 San Ysidro Blvd. San Ysidro, CA 92173 Permit No. FNP 18167, Respondent.	Accusation No. D5389 OAH No. 07-91-12088 STIPULATION FOR SURRENDER OF CERTIFICATE, PERMIT, DECISION AND ORDER

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DEC 21 199.
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IT IS HEREBY STIPULATED by and between the parties in the above-entitled matter as follows:

1. Complainant Dixon Arnett is the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California ("Board") and is represented herein by Daniel E. Lungren, Attorney General of the State of California, by Margaret A. Lafko, Deputy Attorney General.

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2. Suresh Gandotra, M.D. ("respondent") is represented by Evan Ginsburg, Esq., 440 E. Commonwealth, Suite 100, Fullerton, California 92632; telephone (714) 680-3636; fax no. (714) 680-3315.

3. At all times mentioned herein, respondent was licensed by the Board under Physician's and Surgeon's Certificate No. A29677. Said Certificate was issued by the Board on September 10, 1975, and would expire on April 30, 1995. Respondent has no record of prior discipline and is not a supervisor of a Physician Assistant.

4. On April 29, 1991, the Board issued Fictitious Name Permit No. FNP 18167 to respondent for the name of El Norte Clinica Medica, located at 342 West San Ysidro Blvd., San Ysidro, California 92173. Said permit will expire on April 30, 1995.

5. On September 23, 1993, an Accusation was filed against respondent's certificate regarding a felony conviction on May 2, 1990. (See Exh. 1.) This Accusation is pending.

6. On December 16, 1994, an Ex-Parte TRO Petition was filed in the San Diego Superior Court in Case No. SB003494 and a TRO Order was granted restraining respondent and his clinic, El Norte Clinica Medica, from practicing medicine. (See Exh. 2.) This action was based on respondent's criminal conviction and allegations of gross negligence in performing two abortions.

7. Respondent has carefully read and fully understands the contents, force, and effect of this Stipulation for Surrender of Certificate and Permit.

8. Respondent is desirous of surrendering his certificate and permit.

9. Respondent is fully aware of his right to a full hearing on the pending Accusation and on supplemental allegations which would be filed regarding patients A.L.G. and M.O.R. (See Exh. 2.), his right to present witnesses and evidence on his own behalf, his right to cross-examine all witnesses testifying against him, his right to reconsideration, judicial review, appeal, and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and the California Code of Civil Procedure.

10. Respondent admits that he has been convicted of a crime which constitutes a basis for discipline pursuant to Business and Professions Code section 2236 as alleged in the pending Accusation. (Exh. 1.)

11. Respondent admits that he was grossly negligent in treating patient A.L.G. named in the TRO Petition. (Exh. 2.)

12. Respondent understands that in signing this Stipulation for Surrender of Certificate, he is enabling the Division of Medical Quality, Medical Board of California, State of California, to issue its order accepting his surrender of his California Physician's and Surgeon's Certificate No. A29677 without any further notice, opportunity to be heard, or formal proceeding.

13. Should respondent ever seek reinstatement of his surrendered certificate, in addition to the admissions in paragraphs 10 and 11 above, he admits only for the purpose of a reinstatement hearing that his treatment of patient M.O.R. constituted gross negligence.

14. Respondent hereby surrenders his California Physician's and Surgeon's Certificate No. A29677 to the Division

of Medical Quality, Medical Board of California, State of California, for its formal acceptance.

15. Upon formal acceptance of respondent's surrender of certificate by the Division of Medical Quality, Medical Board of California, State of California, respondent further agrees to physically surrender, and cause to be delivered to the Board, both his California Physician's and Surgeon's wall Certificate No. A29677 and wallet certification, as well as permit FNP-18167.

16. Respondent fully understands that upon formal acceptance of his Surrender of Certificate and Permit by the Division of Medical Quality, Medical Board of California, State of California, he will no longer be permitted to practice as a physician and surgeon in the State of California, nor permitted to have any financial interest or control in El Norte Clinica Medica.

17. This Stipulation for Surrender of Certificate and Permit is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties.

18. This Stipulation for Surrender of Certification and Permit shall be subject to the approval of the Division of Medical Quality, Medical Board of California, State of California. If the Division fails, for any reason, to approve

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this Stipulation, it shall be of no force and effect for either party.

DATED: December 22 1994

MARGARET A. LAFKO
Deputy Attorney General

Attorney for Medical Board of California

DATED: 12-22-94

EVAN GINSBURG, ESQ.

Attorney for Respondent

ACKNOWLEDGEMENT

I, SURESH GANDOTRA, M.D., have read the above Stipulation and enter into it freely, voluntarily, intelligently and with full knowledge of its force and effect. I hereby surrender my California Physician's and Surgeon's Certificate No. A29677 and permit FNP 18167 to the Division of Medical Quality, Medical Board of California, State of California, for its formal acceptance. I fully understand that, upon formal acceptance of my surrender of California Physician's and Surgeon's Certificate No. A29677 and permit FNP 18167 by the Division, I will lose all rights and privileges to practice as a physician and surgeon in the State of California.

DATED: 12-22-94

SURESH GANDOTRA, M.D.

DECISION AND ORDER

Pursuant to its authority under California Business and Professions Code sections 2220, 2227, 2234, 2236, and 2285 and based on the stipulations of the parties, the surrender of California Physician's and Surgeon's Certificate No. A29677 and permit FNP 181167 by respondent SURESH GANDOTRA, M.D., is hereby accepted by the Division of Medical Quality, Medical Board of California, State of California.

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Attorneys for Complainant

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DIVISION OF MEDICAL QUALITY

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. D-5389
SURESH GANDOTRA, M.D. 5725 Soto Street Huntington Park, CA 92255	ACCUSATION
Physician and Surgeon Certificate No. A29677,	
Respondent.	

COMES NOW Complainant Dixon Arnett, who as cause for disciplinary action against the above-named respondent, charges and alleges:

1. Complainant is the Executive officer of the Medical Board of California, Department of Consumer Affairs, State of California (hereafter the"Board"), and makes and files this accusation solely in his official capacity.

LICENSE STATUS

2. On or about October 10, 1975, Suresh Gandotra, M.D., (hereafter "respondent"), was issued Physician and Surgeon Certificate No. A29677 was issued by the Board authorizing him to practice medicine in the State of California. At all times relevant herein, said Physician's and Surgeon's Certificate was, and currently is, in full force and effect. Respondent is not authorized to supervise physician's assistants.

3. *Jurisdiction*. Section 2220 of California's Business and Professions Code [hereafter, "the Code"] provides, in pertinent part, that the Division of Medical Quality may take action against all persons guilty of violating any of the provisions of the Medical Practice Act (Chapter 5 of Division 2 of the Code). Section 2227 of the Code provides that a licensee whose matter has been heard by the Division of Medical Quality, by a medical quality review committee or a panel of such committee, or by an administrative law judge, or whose default has been entered, and who is found guilty may:

(1) have his/her certificate revoked upon order of the division;

(2) have his/her right to practice suspended for a period not to exceed one year upon order of the division or a committee or panel thereof;

(3) be placed on probation upon order of the division or a committee or panel thereof;

(4) be publicly reprimanded by the division or a committee or panel thereof; and/or

(5) have such other action taken in relation to discipline as the division, a committee or panel thereof, or an administrative law judge may deem proper.

4. *Summary of Allegations.* This Accusation is brought, and respondent is subject to disciplinary action, pursuant to the following sections of the Medical Practice Act:

A. Code sections 2234(a) and (e) provide as follows:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

". . . ."

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of the physician and surgeon."

B. Code section 2236 provides, in pertinent part, as follows:

"(a) The conviction of any offense substantially related to the qualifications, functions or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record

of conviction shall be conclusive evidence only of the fact that the conviction occurred.

"(b) The division may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if such conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a physician and surgeon is deemed to be a conviction within the meaning of this section."

ALLEGATIONS

FACTS

5. Respondent has subjected his license to discipline under Business and Professions Code sections 2234(a), 2234(e), and 2236, more particularly alleged as follows:

On or about May 2, 1990, respondent was convicted of seventeen felonies including four counts of aiding and abetting the forgery of a prescription, two counts of aiding and abetting the unauthorized practice of medicine, one count of aiding and abetting the furnishing of a dangerous drug without an authorized prescription, two counts of aiding and abetting the unlawful prescription of a controlled substance, one count of aiding and abetting the furnishing of a controlled substance, five counts of presenting a false Medi-Cal claim, one count of grand theft, and

one count of conspiring to present false Medi-Cal claims. The above offenses occurred from January 1, 1985 through July 13, 1988.

DISHONESTY AND CORRUPTION

6. Business and Professions Code section 2234, subdivision (e), defines unprofessional conduct for which the Division of Medical Quality may discipline a licentiate to include "the commission of any act involving . . . dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon."

7. Respondent is also subject to disciplinary action pursuant to section 2234 for unprofessional conduct, as defined by subdivision (e) of that section, in that the matters set forth above at paragraph 5 disclose that he committed acts involving dishonesty or corruption which were substantially related to the functions and duties of a physician when he aided and abetted forgery of prescriptions, unauthorized practice of medicine, unlawful furnishing of dangerous drugs and controlled substances, presenting of false Medi-Cal claims, grand theft and conspiracy from January 1, 1985 through July 13, 1988.

Conviction of an Offense

8. Business and Professions Code section 2236 defines as unprofessional conduct "[t]he conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon . . . ."

9. Respondent is also subject to disciplinary action for unprofessional conduct pursuant to section 2234, subdivision

(a), and section 2236 in that the matters alleged above at paragraph 5 show that he was convicted of an offense as follows:

On July 22, 1990, respondent was convicted by jury verdict of 17 felony counts including charges of aiding and abetting forgery of prescriptions, unauthorized practice of medicine, unlawful furnishing of dangerous drugs and controlled substances, presenting false Medi-Cal claims, grand theft, and conspiracy. On May 2, 1990, in Los Angeles Superior Court, respondent was sentenced to a term in state prison on the above convictions.

WHEREFORE, Complainant requests that a hearing be held on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician and Surgeon Certificate No. A29677, issued to respondent, Suresh Gandotra, M.D.; and

2. Taking such other and further action as the Board deems appropriate.

Dated: 9-23-93

DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

03573160-SD93AD0120

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Attorneys for Petitioner

FILED
KENNETH E. MARTONE
Clerk of the Superior Court
DEC 16 1994
By: _____ Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

SOUTH BAY JUDICIAL DISTRICT, COUNTY OF SAN DIEGO

MEDICAL BOARD OF CALIFORNIA, DIVISION OF MEDICAL QUALITY, DEPARTMENT OF CONSUMER AFFAIRS, STATE OF CALIFORNIA, Petitioner, v. SURESH GANDOTRA, M.D., dba EL NORTE CLINICA MEDICA, Respondent.	NO. SB003493 *EX PARTE* PETITION FOR TEMPORARY RESTRAINING ORDER (§125.7 Bus. & Prof. Code; § 525, et seq. Code of Civ. Proc.) DATE: DECEMBER 16, 1994 TIME: 8:30 A.M. DEPT: D, SOUTH BAY BRANCH

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

SOUTH BAY JUDICIAL DISTRICT, COUNTY OF SAN DIEGO

MEDICAL BOARD OF CALIFORNIA, DIVISION OF MEDICAL QUALITY, DEPARTMENT OF CONSUMER AFFAIRS, STATE OF CALIFORNIA, Petitioner, v. SURESH GANDOTRA, M.D., dba EL NORTE CLINICA MEDICA, Respondent.	NO. *EX PARTE* PETITION FOR TEMPORARY RESTRAINING ORDER (§125.7 Bus. & Prof. Code; § 525, et seq. Code of Civ. Proc.) DATE: DECEMBER 16, 1994 TIME: 8:30 A.M. DEPT: D, SOUTH BAY BRANCH

The Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California, by and through its counsel, Daniel E. Lungren, Attorney General, by Margaret A. Lafko, Deputy Attorney General, alleges:

1. At all times relevant herein, the Division of Medical Quality, has been and now is, a duly constituted division of the Medical Board of California, ("petitioner" or "Board") and is a division within the Department of Consumer Affairs pursuant to sections 2001 and 2003 of the Business and Professions Code and petitioner is charged with the enforcement of Chapter 5 of

Division 2 of the Business and Professions Code (§§ 2000, et seq.; hereinafter the "Medical Practice Act").

2. Petitioner is authorized pursuant to sections 2312 and 125.7 of the Business and Professions Code to seek and obtain an injunction or other order restraining a physician and surgeon, licensed by the Medical Board of California, who has violated, or is about to violate, the Medical Practice Act, from engaging in the practice of medicine, or any part thereof, when said practice will endanger the public health, safety or welfare, by application to the superior court of the county in which said violations have occurred.

3. Section 125.7, subdivision (d), of the Business and Professions Code provides, in pertinent part, that when a restraining order is issued pursuant to said section, an accusation shall be filed before the Board and served upon the respondent not more than thirty (30) days after the issuance of the restraining order. Said section further provides that if the respondent requests a hearing on the accusation, the petitioner must provide the respondent with a hearing within thirty (30) days of said request, and issue a decision within fifteen (15) days from the date of the conclusion of the hearing, or the Court may dissolve the restraining order.

4. On September 10, 1975, respondent Suresh Gandotra, M.D., (hereinafter "respondent") was issued Physician's and Surgeon's Certificate No. A29677 by the Medical Board of California. On September 23, 1993, an Accusation was filed against respondent's certificate based on the felony conviction described herein; this Accusation is pending. (Lgmt. 1 & 2.)

5. The majority of the alleged violations of law described hereinafter have occurred within the County of San Diego, wherein respondent maintained an office at 342 San Ysidro Blvd., Suite N., San Ysidro, California, doing business as El Norte Clinica Medica ("Clinic"). (Lgmt. 1.) Respondent performs only abortions at this clinic. (Decl. 2.)

6. Business and Professions Code section 2004 provides, inter alia, that petitioner has responsibility for the enforcement of disciplinary and criminal provisions of the Medical Practice Act and for reviewing the quality of medical practice carried out by physician and surgeon certificate holders.

7. Respondent has violated the following provisions of the Medical Practice Act:

A. Business and Professions Code section 2227 provides that the certificate of a licensee may be revoked, suspended, or placed on probation.

B. Business and Professions Code section 2234 provides that:

> "The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence;

(c) Repeated negligent acts;

(d) Incompetence;

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

. . . ."

C. Business and Professions Code section 2236 provides that conviction of a crime related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct.

8. Respondent is alleged to have violated provisions of the Medical Practice Act as contained in sections 2234 and 2236 of the Business and Professions Code as follows:

9. CONVICTION

A. On or about May 2, 1990, respondent was convicted of seventeen felonies including four counts of aiding and abetting the forgery of a prescription, two counts of aiding and abetting the unauthorized practice of medicine, one count of aiding and abetting the furnishing of a dangerous drug without an authorized prescription, two counts of aiding and abetting the unlawful prescription of a controlled substance, one count of aiding and abetting the furnishing of a controlled substance, five counts of presenting a false Medi-Cal claim, one count of grand theft, and one count of conspiring to present false Medi-Cal claims. The above offenses occurred from January 1, 1985

through July 13, 1988. On May 2, 1990, in the Los Angeles Superior Court, respondent was sentenced to a term in state prison on the above convictions. (Lgmt. 3.)

10. PATIENT A.L.G.

A. A.L.G., a 22 year old resident of Tijuana, sought an abortion from respondent. She was in her eighteenth week of gestation, her second trimester. Respondent agreed to perform the abortion at his clinic in San Ysidro even though he had not received training in performing second trimester abortions (Exh. 3), and even though he did not have procedures in place to deal with the potential complications attendant to second trimester abortions.

B. In connection with the abortion, respondent had A.L.G. sign a consent form for a first trimester abortion. (Decl. 3.) He did so even though second trimester abortion complication rates are three to four times higher than those for first trimester abortions (Decl. 4), and even though the procedure for second trimester abortions differs from the procedure for first trimester abortions. (Decl. 3.)

C. On May 2, 1991, respondent took the first steps to perform the second trimester abortion on patient A.L.G. by doing a laminaria placement. A.L.G. returned to respondent's office the next day (May 3, 1991) for the actual abortion. Respondent began the abortion, but did not complete it because he could not evacuate the patient. Instead, respondent sent the patient home without medication so that "hopefully" the fetus would drop. (Decl. 3.)

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D. On May 4, 1991, A.L.G. returned to respondent's clinic for completion of the abortion. She was then suffering from an infection (Decl. 3), thereby making the uterus easier to perforate. (Decl. 4.) Nevertheless, respondent attempted, without success, to complete the abortion. (Decl. 3.)

E. In his unsuccessful attempt to complete the abortion of May 4, 1991, respondent, by his own admission, perforated the uterus. (Decl. 3.) Respondent called UCSD Medical Center and spoke with Dr. Johnson. He told her that he had a patient whose uterus he thought he had perforated during an attempted abortion. He said that he thought that he had removed some maternal omentum (part of the mother's intestine) along with fetal parts. He said the patient was sedated with Droperidol, Demerol, Nitrous Oxide and Valium. He said the patient was stable with a blood pressure of 110/70 and a pulse of 72 and that she was not actively bleeding. He did not tell her that the patient was on a dopamine drip. Given that the patient was reported as stable, she authorized him to transport the patient from San Ysidro to UCSD Medical Center rather than the nearest hospital. (Decl. 4.)

F. When A.L.G. arrived at UCSD Medical Center at 4:15 p.m., she was examined by Dr. Donna Johnson. Dr. Johnson found the patient to be in hemorrhagic shock, having suffered a blood loss of at least 40 percent of her total blood volume as indicated by her vital signs upon presentation. Contrary to the representation of the respondent, the patient was not stable. In fact, the patient had been on a Dopamine drip when the paramedics

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arrived at the clinic. The patient was in immediate need of surgery. (Decl. 4.)

G. Dr. Johnson, with Dr. Elaine Hanson attending, performed surgery. During the surgery, it was determined that the patient had a 3 centimeter cervical laceration that extended 4 centimeters into the upper part of the vagina and a 5 centimeter laceration in the dome of the bladder. The damage to the patient was so extensive it was difficult to identify her anatomy. Dr. Johnson removed the fetal parts and placenta which had been left in the patient by respondent. She then repaired the seven centimeter tear of the cervix and vagina. Drs. Sayer and Demby repaired the patient's bladder. (Decl. 4.)

H. On August 7, 1992, during a telephone conversation with Medical Board Senior Investigator M. Dennis Rodriguez regarding patient A.L.G., respondent stated, "I guess I screwed up." (Decl. 3.)

I. Respondent's treatment of patient A.L.G. was reviewed by Dr. Lidia Rubinstein (Decl. 5) and Dr. Benson Harer (Decl. 6). Dr. Rubinstein concluded it was negligent and incompetent. Dr. Harer concluded respondent's treatment was grossly negligent.

J. Respondent's care and treatment of patient A.L.G. constituted repeated negligent acts and gross negligence in that:

1) by agreeing to perform the abortion without proper training and without proper arrangements having been made to treat the patient in the event complications arose, respondent departed from the

standard of care owed to second trimester abortion patients (See Decl. 4); 2) by sending patient A.L.G. home after the first day's failed abortion attempt rather than completing the abortion himself or having it completed by another physician in a proper facility, respondent engaged in an extreme departure from the standard of care by subjecting the patient to dramatically increased risk of infection thereby making the uterus more easy to perforate; by subjecting the patient to the risk of a concealed hemorrhage, which occurs in the uterus behind the fetus or placenta and is not detected because no blood comes from the vagina; and, by subjecting the patient to an increased risk of developing disseminated intravascular coagulopathy, a condition that makes it impossible to operate without the risk of excessive bleeding (Decl. 4); 3) by failing to tell Dr. Johnson that patient A.L.G. was on a dopamine drip prior to being transported, respondent departed from the standard of care (Decl. 4); and, 4) by having patient A.L.G. sign a consent form for first trimester abortions even though she was to undergo a second trimester abortion, respondent departed from the standard of care through negligence (Decl. 5) or dishonesty.

11. PATIENT M.O.R.

A. Patient M.O.R., a resident of Tijuana, was 23 years old when she was treated by the respondent in his clinic on December 7 and 8, 1994, for a therapeutic abortion. Respondent

believed her uterus to be enlarged to 22 weeks when he commenced the procedure. She arrived at the clinic at 9:27 a.m. (Lgmt. 4, pp. 103-108.)

B. Respondent began the abortion procedure at approximately 10:00 a.m. on December 8, 1994. At 11:30 a.m., he was having difficulty extracting all the fetal parts and he stopped the procedure. He removed her from the operating room ("OR") to a bed in another room. Respondent took M.O.R. back into the operating room at approximately 1:30 p.m. Within ten minutes, he realized he perforated the uterus. He saw that he had removed bowel parts. He told the Board investigators, "I knew I screwed up." (Decl. 7 & 8.)

C. At 3:24 p.m., respondent spoke with Dr. Silverman, a resident gynecologist at UCSD Medical Center, and described the condition of his patient. (Decl. 9 & 10.) He told Dr. Silverman that she was 24 weeks gestation, that he had removed the fetus' arms, and that he was unable to evacuate the remainder. Respondent said "I think I lacerated the cervix getting the arms out." When asked if she was bleeding, respondent said "I think she may need blood." At some point, respondent said "I screwed up." (Decl. 10.)

D. Respondent asked directions to the hospital to send her by car, but was told "You have to put her in an ambulance right now." Dr. Silverman agreed on behalf of UCSD to accept transfer of M.O.R. and gave respondent the name and telephone number for Dr. Tipton at Labor and Delivery to make arrangements for M.O.R. (Decl. 10.)

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E. When Dr. Tipton spoke with Dr. Gandotra at 3:46 p.m. on December 8, 1994, regarding the condition of this patient for transport to UCSD, Dr. Gandotra stated that he had started a D&E in the office and had removed the upper extremities and immediately noted bleeding. He was unsure if he had lacerated the cervix or perforated the uterus. He said that she was not bleeding when she was lying down, though if she stood up, she had some bleeding. He said that her blood pressure was 90/70 and when asked what it was prior to the procedure, he said it had been 110/80. He said that she had received 20 milligrams of Valium, had an I.V., and was receiving D5NS. Dr. Gandotra told Dr. Tipton that she was stable for transport to UCSD from San Ysidro. Dr. Tipton told Dr. Gandotra that she should come directly by ambulance to Labor and Delivery. At no time did Dr. Tipton advise Dr. Gandotra to call a "private" ambulance. (Decl. 11.)

F. UCSD Medical Center made preparations for her arrival; the trauma surgeon, the urologist, and the anesthesiologist were notified of her pending arrival. "Trauma" blood was readied for an immediate transfusion. The staff obstetrician/gynecologist qualified to perform 24 week terminations was also ready and they were all waiting on Labor and Delivery for her arrival. By 4:30 p.m., she still had not arrived, but the receptionist received a call from an ambulance service to confirm that UCSD had agreed to accept the patient; verbal communication was given. At 6:10 p.m., she still had not arrived and UCSD called Scripps Chula Vista Emergency Room to see if she had been taken there. It was confirmed that the patient

had been admitted to the ER and Dr. Vandenberg at Scripps confirmed to Dr. Tipton that the patient had been in ventricular fibrillation when the paramedics arrived at the clinic. He had not received any history about the patient's circumstances, (i.e., whether it was drug related or procedure related) and stated that the history given by Dr. Tipton regarding the bleeding at the clinic was helpful. A cardiac resuscitation had been initiated by the time of Dr. Tipton's conversation with Dr. Vandenberg. The patient had a diastolic pressure of 40, had cardiac electrical activity, had received six units of red blood cells, and remained with fixed and dilated pupils. She was bleeding from her vagina and the urethra with unclotting blood and was presumed to be in DIC (disseminated intravascular coagulation). The obstetrician/gynecologist on call had been notified and was en route but Dr. Vandenberg stated that her progress was poor. (Decl. 11.)

G. After speaking with Dr. Silverman and Dr. Tipton, respondent told Board investigators that he tried to call a private ambulance and couldn't get one. A while later, the patient's condition worsened and 911 was called from the clinic. (Decl. 7 & 8.) At 4:25 p.m. on December 8, 1994, American Ambulance paramedics were called to the clinic, arriving at 4:33 p.m. (Lgmt. 5.) Paramedics found her in cardiac arrest bleeding down on the floor with no pulse. (Lgmt. 4, pp. 89, 94.) She was intubated and defibrillated and en route CPR continued, as well as medications and fluids. (Lgmt. 4, p. 94.) CPR was continued en route to the emergency room at Scripps Memorial Hospital, Chula Vista. (Lgmt. 4, p. 94.)

H. The patient arrived in the emergency room at 5:14 p.m., and had no vital signs. (Lgmt. 4, p. 94.) She was unresponsive with fixed and dilated pupils. She was in an idioventricular rhythm on the cardiac monitor without pulses or spontaneous respirations. (Lgmt. 4, p. 97.) At 5:27 p.m., a carotid pulse was felt with a sinus rhythm noted on the cardiac monitor. (Lgmt. 4, p. 97.) She was infused with multiple units of packed red blood cells and transported to surgery at 7:30 p.m. (Lgmt. 4, pp. 97-99.)

I. Upon completion of an exploratory laparotomy incision, a massive amount of blood gushed out. Dr. Arguiano, OB/Gyn surgeon, (with Dr. Gracia also present during surgery), noted a large uterine laceration with a fetal lower extremity protruding out and into the abdominal cavity. He also noted a surgical sponge in the uterus. There were cervical, vaginal and bladder lacerations noted. A female fetus was removed and noted by Dr. Anguiano to be approximately 30 weeks gestational age. The upper extremities and internal organs were traumatically missing. Patient M.O.R.'s rectal sigmoid flexure was avulsed from the mesentery requiring resection from the anal rectal junction to the descending sigmoid. Areas of necrosis and hematomas were noted. A supra cervical hysterectomy was performed. Despite aggressive surgical and fluid resuscitative efforts, M.O.R.'s condition deteriorated throughout surgery. (Lgmt. 4, p. 62; Decl. 12 & 13.)

J. Following surgery, she was transported to surgical intensive care where her condition continued to deteriorate. At 10:17 p.m., she was absent of pulse,

respirations, and blood pressure and at that time, was declared dead. (Lgmt. 4, p. 64-79.)

K. The pertinent records and declarations herein concerning respondent's care and treatment of patient M.O.R. have been reviewed by Dr. Swartz, a Board certified physician in Obstetrics and Gynecology and a Clinical Professor of Reproductive Medicine at the University of California at San Diego. Dr. Swartz has been performing abortions for more than twenty years and performs abortions at all legal gestational ages. (Decl. 14.)

L. In his review of the pertinent records herein, Dr. Swartz has constructed a chronological history concerning this patient beginning with her visit to the clinic on December 7, 1994, at which time the laminaria were inserted for the following day's procedure, and continuing through December 8, 1994, when she died at 10:17 p.m. at the hospital. (Decl. 14.)

Based upon his review, Dr. Swartz has found significant departures from the standard of care:

"a. There was a failure to perform and/or record a pre-operative history and physical.

"b. There was a failure to perform and/or record a pre-operative hematocrit or hemoglobin.

"c. There was a failure to perform and/or record an ultrasound exam to accurately establish gestational age prior to performing an abortion beyond 14 weeks.

"d. There was a failure of the operating surgeon to have hospital privileges at an emergency hospital within a reasonable distance of the surgical facility.

"e. There was a failure of the operating surgeon to have a written transfer agreement with an emergency hospital.

"f. There was a failure of the operating surgeon to have an established plan for handling emergency complications of a procedure noted for risk of serious complications. This is despite a similar complication one year ago.

"g. There was a failure to have sufficient staff to assist with complications of surgery and/or monitor the post-operative recovery phase of surgical patients.

"h. There was a failure to perform and/or record intraoperative findings, monitoring and treatment.

"i. There was a failure to perform and/or record post-operative findings, monitoring and treatment.

"j. There was an extreme delay in initiating appropriate treatment and transfer following the recognition of the serious surgical complication." (Decl. 14.)

M. Dr. Swartz has concluded that the above significant departures from the standard of care individually and collectively represent serious and major departures from the standard of care and contributed to the death of this patient. (Decl. 14.)

N. Respondent's conduct as set forth hereinabove in paragraphs 9, 10, and 11 constitutes acts of unprofessional conduct in violation of sections 2234 and 2236 of the Business and Professions Code in that respondent has been convicted of a

felony related to the practice of medicine and is guilty of gross negligence, incompetence, and repeated negligent acts in performing abortions on these two patients, resulting in serious injury and death.

12. **RESPONDENT'S QUALIFICATIONS AND PROCEDURES IN PERFORMING ABORTIONS AND HIS STATEMENTS REGARDING PATIENT M.O.R.**

A. In a conversation on December 9, 1994, with Dr. Moore, Director of Perinatal Medicine at UCSD, respondent claimed that he performs over 100 abortion procedures each week and that he has been doing this for 20 years. He has not been trained in abortion procedures and he is not an OB/Gyn physician, but rather an emergency medical physician who stated that he "came into this work because patients needed me." (Decl. 15.) Respondent does not have any admitting privileges at any hospital and he does not have any transportation relationships in place for his patients to be transferred to a hospital in the event of a complication or emergency. (Decl. 15.)

B. Regarding patient M.O.R., Dr. Gandotra admitted to Dr. Moore that she began bleeding during the procedure and that he recognized it was excessive and called UCSD Medical Center to transport her there. He said that the patient would not allow him to do this and that she actually wanted to get up and walk home. When asked if he had back-up or transportation agreements for his patients, he stated: "I prefer my patients go to University and that's who I called first." (Decl. 15.)

C. He stated that after he finished calling the University on the afternoon of December 8, 1994, he went back to

check on M.O.R. She was looking worse and he was also checking on other patients, going room to room, and when he came back to check M.O.R. again she was in shock or coding, and he administered mouth-to-mouth resuscitation, then intubated, and started CPR. Dr. Gandotra stated that he was working on M.O.R. and doing CPR when the ambulance arrived and he directed them to Scripps Hospital in Chula Vista. (Decl. 15.)

D. When asked why he did not ride with M.O.R. in the ambulance to the hospital, respondent stated initially that he did not have privileges at that hospital. When asked a second time why he did not accompany the patient, he stated that "he had other patients to watch." (Decl. 15.)

14. AUTOPSY OF M.O.R. AND INFANT

A. Christopher I. Swalwell, M. D. is the medical examiner who performed the autopsy on patient M.O.R. and her baby on December 9 and 10, 1994. Of the 3,000 autopsies he has performed, approximately 100 included fetuses, newborns, and stillborns in which he determined gestational age. Dr. Swalwell concluded that the baby was approximately 26 to 28 weeks gestation. The baby died as a result of the therapeutic abortion. The body of the baby was not complete when autopsied. Both arms had been cut off; the heart, lungs, liver, and other organs had been cut out, the front of the chest and abdomen were missing, the right femur was fractured, the head was intact except for an area on the scalp which had been taken off from the back of the head. The autopsy photos, which are attached to Dr. Swalwell's Declaration, depict the mother and baby. (THESE

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PHOTOS WILL BE PROVIDED TO THE COURT AT THE HEARING AND ARE NOT FILED HEREIN.) (Decl. 16.)

B. Dr. Swalwell has tentatively opined that the cause of death on M.O.R. was complications of the acute pelvic injuries which consisted of lacerations of the lower uterus, vagina, bladder and colon. (Decl. 16.)

15. EL NORTE CLINICA MEDICA

A. Respondent practices medicine in San Diego County at the El Norte Clinica Medica where he performs abortions. No other medical practice is provided at the clinic. Respondent is the only physician who practices in the clinic and he has one employee, Shirley Riles, who acts as an office manager. On December 13, 1994, Dr. Buncher toured the clinic with Ms. Riles who provided information regarding the clinic's operation. She greets patients, explains procedures, obtains the medical consent, and initial intake information. She speaks English and Spanish and has no medical training. The clinic consists of a reception area, a recovery room, a treatment room, and a bathroom, all connected by a single hallway. (Decl. 2 & 17.)

B. No blood or blood products are maintained at the clinic. Lab work performed at the clinic consists of pregnancy tests and tests for the RH factor, done by Ms. Riles. No other preoperative or post-operative lab tests are done. Tissue specimens are not sent out for examination and evaluation. There is no area in the clinic for lab work. The medical records used in the clinic consist of three full sheets of paper and two half sheets. The full sheets contain the consent form, a

procedure description with pre-op and post-op instructions, and an advisement sheet with instructions about what the patient should do in case of complications. The consent form only covers pregnancies done in the first thirteen weeks of gestation. The consent form implies that trained medical personnel, other than just Dr. Gandotra, work at the facility, that special diagnostic procedures are available to the patient, and that tissue is examined by a pathologist. Ms. Riles records the patient's last menstrual period (LMP), her RH status, and other intake information. This same half sheet is then used by Dr. Gandotra for his notes. No other records are used or kept. (Decl. 17.)

C. Respondent does his own anesthesia and uses Droperidol, Nitrous Oxide, and Oxygen. After the abortion, Ms. Riles checks on the patients and asks whoever accompanied the patient to sit with the patient. The patient is instructed to return to the clinic after two weeks for follow-up. Approximately 20 percent of the patient caseload returns for the follow-up visit. Patients are not contacted if they miss a follow-up because often the names and phone numbers given are fictitious. Patients are told to call for excessive pain or bleeding yet the clinic does not take after hours calls. Consequently, if a patient experiences problems after hours, the patient is told to call an emergency room. Respondent has no back-up physician, does not take after hours calls, and does not have any hospital privileges. (Decl. 17.)

D. All of these facts demonstrate that respondent is practicing well below the standard of care and in a grossly negligent manner. Inadequate patient identification

information is obtained. No log of patients treated is maintained. There is no form on which the patient may self-identify any past medical problems or family history. An appropriate history and physical are not done nor is any preoperative lab work obtained. The consent form is misleading and inadequate. The patients are virtually abandoned by Dr. Gandotra after the procedure is completed because he does not take after hours calls nor does he have back-up. Dr. Gandotra is not assisted by any trained medical personnel. Ninety-five (95) percent of the patients are Spanish- speaking, yet respondent does not speak Spanish. Respondent's practice of medicine in this setting and the operation of the clinic endangers the public health, safety and welfare. (Decl. 17.)

WHEREFORE, petitioner prays that this court grant relief as follows:

1. That respondent Suresh Gandotra, M.D. be restrained and enjoined by way of a temporary restraining order pursuant to Business and Professions Code section 125.7 from practicing or attempting to practice medicine, advertising or holding himself out as practicing any system or mode of treating the sick or afflicted of this state, or diagnosing, treating, operating for, or prescribing for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physician or mental condition of any person or in any other manner or means of practicing medicine, until a hearing can be held on the Accusation filed with the Medical Board pursuant to Business and Professions Code section 125.7(d) and the

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Supplemental Accusation which will be filed alleging the grossly negligent treatment of these two patients.

2. That El Norte Clinica Medica be closed and that respondent be restrained from any future control of its operations as a medical office, clinic, or other medical facility.

3. That the petitioner have such other and further relief as the nature of the case may require and the court deems appropriate to protect the public health, safety, and welfare.

DATED: December 15, 1994

Respectfully submitted,

DANIEL E. LUNGREN, Attorney General
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